DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **NOTIFICATION OF PERSONNEL CHANGE FORM HOSPITAL PROGRAMS** REFERENCE NO. 621.2

HOSPITAL PROGRAMS

Organization's Name: _____

Effective Date: _____ (Check all that apply)

[ ] Personnel Change

Hospital:

[ ] Base Hospital Medical Director
[ ] Chief Executive Officer (CEO)
[ ] Disaster Coordinator/Emergency Management Officer (EMO)
[ ] EDAP Medical Director
[ ] ED Medical Director
[ ] ED Nurse Manager/Director
[ ] Pediatric Liaison Nurse (PdLN)
[ ] PMC/PTC Liaison Nurse
[ ] PMC/PTC Medical Director
[ ] Prehospital Care Coordinator (PCC)
[ ] Stroke Medical Director
[ ] Stroke Program Coordinator
[ ] SRC Clinical Director
[ ] SRC Medical Director
[ ] Trauma Medical Director
[ ] Trauma Program Director
[ ] Trauma Surge Coordinator

Change Name From: _____

Change Name To/Add: _____

[ ] Change Address/Contact Numbers

_____ _____
Address/Street City/State/Zip

_____ _____
Telephone Fax

_____ _____
Telephone: Disaster Command Post Fax: Disaster Command Post

_____ _____
Pager Number/Cellular Number E-mail address

_____ _____ _____
Name of person completing form Title Date